

CAMH STRATEGIC PLAN RENEWAL

ENVIRONMENTAL SCAN

December 2005



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CAMH STRATEGIC PLAN RENEWAL – ENVIRONMENTAL SCAN

CONTEXT:

The Centre for Addiction and Mental Health (CAMH) is nearing the completion of its second 3-year strategic planning cycle (i.e., 1999-2002, 2003-2006). CAMH went through an extensive consultative process involving staff, clients and other stakeholders to develop its mission, vision and values as presented in the 2003-2006 Strategic Plan. CAMH's mission, vision, values and commitments, and seven strategic goals will continue to guide the organization in the development of its third Strategic Plan for 2006-2009.

During the term of CAMH's next Strategic Plan (2006-2009), we anticipate dramatic changes to the health care system in Ontario as a result of the government's Transformation Agenda. While change processes have already been initiated, they are still in the early stages and CAMH's renewed Strategic Plan must be flexible enough to guide the organization through the transformation to come. As well, CAMH will be challenged to provide programs and services within a constrained fiscal environment.

CAMH will undertake a more in-depth, comprehensive examination of its strategic priorities once the Transformation Agenda is more fully implemented, and once accountability requirements and systems are more fully understood and developed - likely to coincide with the completion of CAMH's third 3-year strategic planning cycle (i.e., 2006-2009).

This environmental scan has been developed to inform the renewal process which will identify strategic priorities that will have a major influence on CAMH's ability to meet its corporate mission, vision and values in 2006-2009. An attempt has been made to highlight and summarize new and emerging developments, pressures and potential opportunities in the broad health care system, the mental health and addictions landscape, and at CAMH. This environmental scan will be used to develop options and key questions that will be used during a contained consultation process.

A. HEALTH CARE SYSTEM LANDSCAPE: FOCUS ON REFORM AND ACCOUNTABILITY

Canadians value their health care system. Both the federal and provincial governments have significant roles in the financing and delivery of health care to Canadians. Concerns about access to quality care and sustainability have resulted in various initiatives to reform the system.

FEDERAL GOVERNMENT / NATIONAL HEALTH CARE INITIATIVES:

The tabling of the Romanow Commission and the Kirby Commission reports in 2002 set the stage for federal government initiatives to support reform within the health care system.

2003 First Ministers' Accord on Health Care Renewal: The February 2003 Accord - agreed to by the federal, provincial and territorial Ministers of Health - increased federal funding to the provinces and territories to support health care reform, and included a number of components intended to improve accountability within the health care system. A five-year, \$16 billion Health Reform Transfer (HRT) was created to help provinces and territories accelerate reform in three priority areas – primary care reform, home care, and catastrophic drug coverage. The First Ministers agreed to prepare annual public reports on progress achieved and key outcomes in each of the reform areas. Funding provided under the HRT is allocated on an equal per capita basis, and will be integrated into the Canada Health Transfer (CHT) starting in 2005-06. As it relates to mental health and addictions, the Accord includes mental health and addictions within a national home care program; addresses the needs of people with mental illness for access to prescription drug coverage; and includes mental illness and addictions within primary care reform initiatives.

10-Year Plan to Strengthen Health Care (2004): This Plan was signed by the federal, provincial and territorial First Ministers in September 2004, and allows for provinces and territories to receive additional funding of \$41 billion for health over 10 years. This funding is to be used to strengthen ongoing federal health support provided through the Canada Health Transfer (CHT), meet financial recommendations from the *Royal Commission on the Future of Health Care in Canada* (Romanow Report), and address wait times to ensure Canadians have timely access to essential health care services.

Meetings of First Minister's, Ministers of Health: The Annual Premiers' Conference takes place in August and Alberta Premier Klein hosted the provincial and territorial leaders in 2005. The agenda was not squarely focused on health (as it was in 2004 with the subsequent agreement on the 10-Year Plan). Any federal, provincial, territorial discussion will likely focus attention on the "care guarantee" given the recent Supreme Court decision (Chaoulli case). The care guarantee is now one of Prime Minister Martin's top priorities. At a meeting with Senator Michael Kirby - who recommended the concept as Chair of the Standing Senate Committee on Social Affairs, Science and Technology in 2002 - it was agreed that the federal government would work with the provinces on achieving timely care and that Health Canada would launch an immediate in-depth study on care guarantees as a method for eliminating unacceptable delays in treatment (Globe and Mail, July 23, 2005). In the Kirby Commission interim report (see below), the Commissioners raised the issue of whether there is a need to set national standards with regard to access to mental health services and addiction treatment.¹ The regular meetings of First Ministers and Ministers of Health play a pivotal role in reshaping federal provincial relations and health care reform.

Health Council of Canada: A key commitment of the 2003 First Ministers' Health Accord was the establishment of the Health Council of Canada (December 2003) – a not for profit corporation funded by Health Canada. The Chair and 25 Councillors were appointed in December 2003. The mandate of the Council is to monitor and make public reports on the implementation of health care renewal in Canada. To fulfill its mandate the Council draws upon feedback provided in consultations, existing reports, work of the Federal/Provincial/Territorial Advisory Committee on Governance and Accountability, and the Canadian Institute of Health Information (CIHI).

Public Health Agency of Canada (PHAC): The new PHAC was launched in September 2004 with the appointment of Canada's first Chief Public Health Officer – Dr. David Butler-Jones². The creation of PHAC was the result of broad consultation with the provinces, territories and non-government stakeholders, and followed recommendations from Dr. David Naylor's report, *Learning from SARS: Renewal of Public Health in Canada*, as well as other Canadian and international reports that called for clear federal leadership on issues concerning public health. As part of its development of strategic priorities and action plans, PHAC hosted roundtable consultations across the country to examine how public health goals should be established in Canada. A committee headed by Dr. Carolyn Bennett, the federal Minister of State for Public Health, and Theresa Oswald, Manitoba's Minister of Healthy Living, is currently drafting public health goals that are expected to be approved by the provinces by year's end. The base funding of PHAC has risen from \$3 million to \$18 million as a result of funding made available through the 2003 Health Accord and 2004 10-Year Plan.

Integrated Strategy on Healthy Living and Chronic Disease: In October 2005, the federal government - through the Public Health Agency of Canada – announced \$300 million investment in health promotion and disease prevention. The new funding is to address healthy eating, physical activity and

¹ "Mental Health, Mental Illness and Addiction: Issues and Options for Canada". Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology. November 2004.

² PHAC was a partner with CAMH, Centre for Health Promotion at the University of Toronto, CMHA, and the Netherlands Radboud University Nijmegen in hosting the International Mental Health Promotion Summer Institute in July 2005. Dr. Butler-Jones was a keynote speaker at the Institute.

healthy weights – key risk factors for some of the leading, preventable chronic diseases (News Release, October 20th, 2005). The Strategy is intended to contribute to the sustainability of the health care system by working to reduce the burden of disease in Canada. It is an Integrated Strategy in that a diversity of partners from various sectors and jurisdictions are expected to collaborate to develop stronger public policies and more integrated, evidence-based and responsive health systems. The funding will be allocated to the following components: investment in the Integrated Pan-Canadian Healthy Living Strategy; investment for integrated chronic disease prevention; enhanced surveillance for chronic disease; enhancement of the Canadian Diabetes Strategy; new investment in the Canadian Strategy on Cancer Control; and development of a Canadian cardiovascular strategic framework and action plan. As well, \$4.5 million over 5 years and \$1 million per year ongoing will be used to identify gaps in mental health related policies in Canada, and develop policy responses to the final report of the Kirby Commission and the National Framework on Substance Use and Abuse (see below).

Electronic Health Record (EHR) and E Health Initiatives: EHR and E-health initiatives (e.g., telehealth, telemedicine, telepsychiatry) are key to health system renewal. An EHR system is a secure, private, and comprehensive lifetime record of health history and care that is generated by one or more encounters in the care delivery setting (including visits to physicians/specialists, hospital stays, prescription drugs, laboratory tests, etc.). The record is available electronically to its individual owner and those health care providers who have been authorized by the owner to access it in support of high quality care (including quality and timeliness of care, system efficiency and accountability). E-health is an emerging field that combines health services and information delivered or enhanced through electronic information and communication technologies to improve health care at all levels. The federal government has committed \$1.2 billion to work with the Canada Health Infoway to realize the vision for an EHR and E-health initiatives. The federal government has supported 75% for committed projects (with a 25% provincial government contribution), with payment schemes linked to measured progress. The development and implementation of EHR is a global phenomenon – the U.S. President recently appointed an EHR czar; Sweden, Denmark, France and England have committed significant resources to developing electronic health records.

CANADIAN COUNCIL ON HEALTH SERVICES ACCREDITATION (CCHSA):

Investigating and improving patient safety in health care is gaining prominence internationally. In the United Kingdom, the National Patient Safety Agency was recently established, and the Center for Quality Improvement and Patient Safety has been established in the United States. CCHSA has adopted a patient safety strategy and is taking an active role in enhancing patient safety in the Canadian healthcare system. Starting in 2005, hospitals will be expected to adopt CCHSA's new patient safety goals and required organizational practices in order to achieve accreditation recognition status in the future. The goals cover the areas of culture, communication, medication use, work life/workforce, and infection control. Specific, evidence-based practices have been identified for each goal that will help organizations enhance patient safety, including conducting one safety related prospective analysis of high-risk practices per year.

PAN-CANADIAN JOINT CONSORTIUM FOR SCHOOL HEALTH:

In October 2004, the Provincial and Territorial ministers of Education and Health and the Public Health Agency of Canada, agreed to establish a Pan-Canadian Joint Consortium for School Health (JCSH) to facilitate a comprehensive and coordinated approach to health programs and services delivered in the school setting. In May 2005, Ontario named a School Health Coordinator as part of its commitment to joining the JCSH. Reporting jointly to the ministries of Education, and Health and Long-Term Care, the Coordinator will play an important role in bringing together these two systems, and others, to focus on ensuring the healthiest schools possible for the learning, growth and development of young people in Ontario. Numerous "healthy schools" initiatives have been initiated across the province over the last 15 years, emerging as a result of strong school board – public health unit partnerships. In addition, a strong "living schools" pilot project through the Ontario Physical & Health Education Association (Ophea) has been developed for individual schools interested in promoting the health of their children

and youth. In June 2005, the Ontario Healthy Schools Coalition submitted a report to the provincial government (including the ministries of Health and Long Term Care, Education, Children and Youth, Recreation and Tourism) focusing on four priority areas of action to effectively act on the momentum and widely disseminate “healthy schools” across the province. Specific recommendations for the priority areas - provincial policy and coordination, funding and personnel, awareness raising and consultation, and assessment and evaluation – were included. It is also anticipated that the provincial Minister of Education will announce a Safe Schools Action Plan, including bullying prevention, in the near future.

PROVINCIAL TRANSFORMATION AGENDA:

“Client-centred care. Integration. Community-based services.”

The provincial government’s priorities for health care includes:

- putting hospitals on stable financial footing;
- reducing wait times for key procedures;
- improving access to doctors and nurses, including the creation of Family Health Teams; and
- investing in community-based health care in order to reduce pressure on hospitals and deliver care closer to home (News Release - June 21, 2005).

In September 2004, the provincial government announced its intent to implement reform in the health care system to create “a comprehensive and integrated system of care that is shaped with the active leadership of communities and driven by the needs of the patient” (News Release - September 2004). Primary care reform, investments in community-based services, expanded access to homecare and long-term care, and establishment of local health integration networks (LHINs) were identified as key components of the Transformation Agenda.

CAMH, in partnership with the Canadian Mental Health Association (CMHA) Ontario and the Ontario Federation of Community Mental Health and Addiction Programs (Ontario Federation), hosted a sector consultation in September 2004. This consultation contributed to a sector response to the government regarding the planning and implementation of the transformation agenda (released October 6, 2004), and consistent messaging at the 14 community workshops hosted by the Ministry of Health and Long Term Care (MOHLTC) in November and December 2004. In 13 of these consultations, mental health and addictions was identified as one of the top five priority areas.

CAMH, CMHA-Ontario and the Ontario Federation developed the following critical success factors for a transformed mental health and addictions system:³

- Addiction and mental health care will be fully integrated within a transformed system.
- Consumers and families will be involved in all aspects of planning, decision-making, implementation and service delivery.
- People across Ontario will have access to the best mental health and addiction services in their communities, supported by widely shared research findings, best practices and professional development.
- There will be a continuum of mental health and addiction services and supports from community-based to hospital care, and including consumer and family initiatives.
- Access to housing, income, employment, social supports and other determinants of health will be acknowledged and supported as critical aspects of treatment and recovery.
- Mechanisms for addressing the historical marginalization, stigma and under-funding of addiction and mental health services will be in place.
- The needs of diverse, rural and remote communities will be met.

³ “A Strong Provincial Focus for the Addictions and Mental Health Sector in Ontario” (May 2005); CAMH, CMHA-Ontario, Ontario Federation of Community Based Addictions and Mental Health Programs.

CAMH, CMHA - Ontario, and the Ontario Federation will work to develop indicators to measure the extent to which these critical success factors are met as the transformation agenda proceeds.

CAMH and its partners also advocated for a strong provincial role to complement and support regional and local planning and implementation. The partners hosted another consultation in March 2005, and CAMH commissioned a review of mental health and addiction services in jurisdictions with regionalized governance structures to inform thinking about this provincial role.⁴ The following cross-regional functions and capacities were identified as critical to the creation of an integrated, coordinated system:

- policy frameworks;
- system-wide performance monitoring;
- health promotion and prevention focus;
- health human resources and workforce development; and
- best practices dissemination and research.

Accordingly, CAMH, CMHA-Ontario and the Ontario Federation have advocated for the creation of a formal provincial network / authority of addictions and mental health clients, service providers, researchers, and planners from across the community / hospital continuum to fulfill cross-regional functions, develop tools for the sector to participate in LHINs and other health care reform initiatives, and to serve in an advisory capacity to government.

The fourteen LHINs have been incorporated and their founding leadership was announced in June 2005. Bill 36: the *Local Health Integration System Integration Act, 2005* was introduced by the Minister of Health and Long Term Care on November 24, 2005. LHIN plans are due in September 2006 and it is currently assumed that they will not require Ministry approval prior to implementation.

It should also be noted that within a transforming health system, the *Health Protection Privacy Act*⁵ includes two key transformational components – the Act enables the establishment of an EHR, and the legislation encourages consumer empowerment.

COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2004:

The provincial *Commitment to the Future of Medicare Act, 2004* became law on June 17, 2004. The Act improves publicly-funded health care in the province by:

- adding a new principle – accountability – to the fundamental principles of medicare as laid out in the Canada Health Act, through a new requirement that transfer payment recipients enter into accountability agreements with the government;
- strengthening the prohibition of “two-tier” medicine by closing legislative loopholes that allow queue-jumping, extra billing and user fees; and
- establishing an independent Ontario Health Quality Council to monitor and report to Ontarians on the state of the health care system in order to determine where improvements are needed and where progress is being made.

Prior to passage of the legislation, CAMH and CMHA -Ontario - in separate submissions to the Standing Committee on Justice and Social Policy (March 2004) - advocated for amendments to the Preamble of Bill 8 to ensure that people with mental illness and addiction problems be entitled to equal benefits of publicly funded programs and that these services be considered essential for the mental and physical health of Ontarians. The Preamble in the Act was revised to include reference to

⁴ “Mental Health and Addiction Services in Regionalized Health Governance Structures: A Review” (March 2005); Macfarlane, D. and Durbin, J. Health Systems Research and Consulting Unit, CAMH.

⁵ Citizen privacy is a global issue that evolved during GATT negotiations (General Agreement on Tariffs and Trade) - negotiations for inter-country commerce highlighted the need for international privacy legislation.

“community mental health”, but references to “addiction” were not included. In its submission, CAMH also advocated for a number of other recommendations - that principles of transparency and collaboration guide the development of new accountability mechanisms, and that the Ontario Health Quality Council have a specific mandate to study and report on the mental health and addictions sector.

PROVINCIAL GOVERNMENT - HOSPITAL FINANCING:

The following commitments have been made in recent provincial government announcements:

- Starting in 2005-06, hospitals have received multi-year funding allocations – for the first time ever, hospitals will know their operational budget for the next three years. Overall, Ontario hospitals will receive \$12.3 billion in 2005-06, at least \$12.6 billion in 2006-07, and \$13.1 billion in 2007-08 (or at least \$1.75 billion in new funding over the next three years).
- The funding announcements for 2006-07 and 2007-08 does not include additional dollars for wait times and some priority programs that will be announced in the next fiscal year for those hospitals that deliver the expected results.
- A commitment to the Balanced Budget Process - the MOHLTC will continue to work with hospitals to get them out of – or keep them out of - deficit.
- In collaboration with hospitals, a funding formula has been developed that is informed by the specific needs and different sizes of hospitals, efficiency of hospitals, and growth in demand for services.

Implications of these funding announcements for CAMH will be discussed in section C.

Revenue from the MOHLTC to hospitals over the last five years (2000/01 to 2004/05) increased by \$4.3B or 50%. However, the pace of increase decreased dramatically from 2003/04 to 2004/05 when total revenues increased by 7.8%, accounting for inflation, new and expanded programs, PCOPs and their annualization, wait lists, other votes, etc. On the other hand, total expenses increased by \$1.55B between 2003/04 and 2004/05 (10.3%). Of this increase, compensation costs increased by \$1.09B (11%). In 2004/05, compensation costs represented 67% of total costs and 70% of the total increase in expenses year over year. In 2004/05, hospitals reported a net deficit of \$127.2M - teaching hospitals accounted for \$11.8M deficit while the chronic/rehab/mental health hospitals had a \$2M surplus as a group.

Regarding capital funding, Ontario’s hospitals require \$7B to \$9B in infrastructure renewal and capacity expansion. With \$5.3B allocated from the Ministry of Public Infrastructure Renewal (MPIR) for hospital infrastructure over the next 5 years, Alternative Financing and Procurement (AFP) models could play an important role in the strategic investment of capital dollars into hospitals. Much work needs to be done in finalizing the approach and details for AFP models. However, AFP models enable hospitals to gain access to private sector capital and expertise with risk transfer to the appropriate partner. According to the MPIR, “AFP will allow Ontario to finance and implement many, large infrastructure projects better and sooner, without tying up public funds that can be used for other purposes”.

Other recent provincial government announcements include:

- Investments to support primary care reform – establishment of 54 Family Health Teams (FHTs) and 3 networks of FHTs to improve access to primary care for over 2 million Ontarians in 47 communities; an additional \$30 million between 2003-04 to 2005-06 to expand primary care services to 350,000 Ontarians through 54 Community Health Centres (CHCs).
- Unprecedented investments in community-based care, including home care and community mental health services (see section B).
- Increased provincial government’s share of public health unit funding from 50% to 75% by January 2007.

As well, the provincial government's *ReNew Ontario* is a five-year, \$30 billion infrastructure investment plan that commits \$5 billion to health care infrastructure (Ministry of Public Infrastructure Renewal).⁶

PROVINCIAL SUPPORTING STRUCTURES:

Ministry of Health Promotion: The appointment of a new Minister of Health Promotion responsible for a dedicated portfolio to promoting healthy living and illness prevention was announced in June 2005. The Honourable Jim Watson is the new Minister, and the Honourable Peter Fonseca is his Parliamentary Assistant. Marg Rappolt assumed the position of Deputy Minister at the end of August 2005. A transition team has been established to determine the list of potential programs for transfer to the new Ministry (e.g., Chronic Disease Prevention and Health Promotion Branch of the MOHLTC, and the Recreation component of the Tourism and Recreation Ministry). It has been noted that there is a risk that in separating health promotion from the MOHLTC the benefits of health promotion with its recognition of the importance of the determinants of health may not be integrated throughout the health system. Other concerns include the potential for overlapping mandates that could complicate processes for stakeholders.

Ontario Health Quality Council: The Ontario Health Quality Council is a component of the *Commitment to the Future of Medicare Act*. The mandate of the Council is to monitor and report to Ontarians on access to publicly funded health services and health professionals, population health status, and health system outcomes. In September 2005 the provincial government announced the membership of the Council – including Ray Hession (Chair), Victoria Grant (Vice-Chair), Lyn McLeod (cross appointment with the Health Council of Canada), and eight members. The Council will report annually to the Minister of Health and Long Term Care, and its reports will be shared with the public. A first report is expected in the Spring 2006 with a progress report on the government's health priorities of wait times, creation of Family Health Teams, and promotion of health and wellness.

Health Professions Regulatory Advisory Council (HPRAC): HPRAC provides independent policy advice to the Minister of Health and Long Term Care on matters related to the regulation of health professions in Ontario. HPRAC has a statutory mandate under the *Regulated Health Professions Act (RHPA, 1991)* with duties to determine whether health professions should be regulated or de-regulated. The Minister has requested advice as to whether psychotherapists should be regulated under the *RHPA* as a profession, what their scope of practice should be and what controlled acts they should be authorized to perform. HPRAC completed a literature and jurisdictional review, and hosted a two-day consultation in July 2005. CAMH submitted a detailed response to questions posed by HPRAC in advance of the consultation, and participated in the consultation along with representatives of regulatory bodies and professional associations of both regulated and unregulated professions. The outcome of the consultation was agreement that there should be a regulatory framework for the practice of psychotherapy in the province. In August, HPRAC distributed a document outlining various options of regulation, including regulation that can encompass qualified unregulated professionals. CAMH provided a written response to the HPRAC consultation report in October, recommending that the practice of psychotherapy should be regulated in order to protect the public interest and provide a process for education, complaint and discipline.

Public Health Agency for Ontario: The MOHLTC is committed to the establishment of a Public Health Agency by 2006-07. An Agency Implementation Task Force was established to advise the Ministry on the design, development and implementation of the Agency. The Task Force presented Part 1 of its report in October 2005 with a proposed mandate, vision, mission and values for the Agency, and fifteen initial recommendations focused on governance (i.e., a scheduled agency of the MOHLTC), program areas (infectious diseases, health promotion, chronic disease and injury prevention, environmental health, and emergency management support), and functions (surveillance and epidemiology, research, knowledge exchange, specialized laboratory diagnostics, professional development, and communication). The Task Force will submit its final report by the end of 2005 with

⁶ *ReNew Ontario* is the infrastructure investment plan that is supporting CAMH's redevelopment initiative.

further recommendations regarding the implementation of the Agency (e.g., priorities for the first three years, overall operating budget, capital plan, phasing-in of program areas and functions, etc.).

Ontario Hospital Association (OHA): The OHA was founded in 1924 as an independent, non-profit organization. CAMH's President and CEO is a member of the Advocacy Committee, a standing committee of the OHA Board, which has a mandate to respond to funding and policy concerns. Since the mid 1990's, the OHA has given specialty mental health hospitals and acute hospitals with mental health units a voice within OHA.

- The *Mental Health Working Group* was active from 1998 to 2004 – CAMH's President and CEO served as Chair of this Working Group.
- The *Mental Health and Addiction Provincial Leadership Council* was established in March 2005 with a mandate to advocate and make recommendations to OHA in the development of health care policy; communicate to government and external stakeholders on issues impacting on mental health and addictions; and provide a forum for shared communication and education. Membership of the Council consists of CEO representatives from both specialty mental health hospitals (including CAMH's CEO) and acute hospitals with mental health beds and/or large addiction programs.

The OHA also established an *Integration Task Force* in response to the government's launch of its Transformation Agenda. The Task Force has multi-sectoral representation and is looking at what services hospitals and community-based organizations should be delivering in a transformed system.

Council of Academic Hospitals of Ontario (CAHO) - OHA: Twenty-two hospitals in Ontario have teaching or research affiliations with one of the five university medical (or health sciences) schools. As such, there are five academic health science "centres" in the province - London, Hamilton, Toronto, Kingston, and Ottawa. A sixth centre is emerging in Sudbury and Thunder Bay, through the Northern Ontario Medical School. CAHO provides a focal point for strategic initiatives on behalf of this group of hospitals. CAHO started in the mid 1980's primarily as a discussion group for Chief Executives on administrative matters, but its role has evolved to meet the challenges of providing health care management and services in a complex environment. There are now five CAHO sub-committees, lead by the CAHO Council of CEO's, with over 100 senior clinical and non-clinical staff. As a teaching hospital with a research affiliation with the University of Toronto, CAMH is a member of CAHO. CAMH will need to look at its role as a teaching hospital and make strategic decisions regarding how this role may change as the health system in Ontario changes (e.g., an increased focus on training primary care physicians and community mental health workers, a greater emphasis on specialization in our programs and services and less on initiatives that others in the system could do, etc.).

Toronto Academic Health Sciences Network (TAHSN), University of Toronto: TAHSN's predecessor – the Toronto Academic Health Science Council - was established by the University of Toronto and the fully-affiliated teaching hospitals in 1992. Membership includes the Presidents/CEOs of the fully-affiliated teaching hospitals, the University of Toronto President, the Chair of the Council of Health Science and Social Work Deans, the Dean of Medicine/Vice-Provost, Relations with Health Care Institutions, and the University Vice-President, Research and International Relations, ex officio. TAHSN serves as an important vehicle for dealing with issues of mutual interest. TAHSN has been involved in addressing acute mental health issues, along with neurosurgery and vascular surgery issues, and is participating in the Hospital Back Office Transformation project (see section C).

Provincial E-Health Council: The provincial government's e-Health strategy is working closely with Canada Health Infoway on the development of compatible e-health information systems (including websites such as eHealthOntario.ca that deliver information and important health notices, and the EHR initiative). The provincial e-Health Council is currently going through a review process that is expected to result in updated membership so that the Council can more effectively oversee implementation of the provincial e-Health strategy as mandated by the Smart Systems for Health Agency. There is a strong recognition that the provincial e-Health strategy must be clearly linked to the provincial Transformation Agenda – e-Health is increasingly viewed as an enabler for breaking down traditional silos in the health care system and for building an integrated health system. The Ontario Continuing Care e-Health Council is one of six sector e-Health councils (the other sectors are

public health, physician, hospital, laboratory, pharmacy). The Continuing Care Council represents that broadest and most diverse sector within e-Health (e.g., including community care access centres, mental health and addiction organizations, home care and community support providers, long term care homes, and MOHLTC representatives).⁷ CAMH has senior level representation on this sector Council, and is actively involved in the development of Council priorities – management information systems, common assessment tools/processes, and connectivity with care providers in the broader health sector. The Council expects to deliver practical processes and tools to electronically gather and exchange information to enhance continuing care for providers, patients and clients.

SUMMARY:

- Health care is a major concern for Canadians.
- Both federal and provincial governments consider health care as a priority issue and recognize that the Canadian public has concerns about the future of public health care.
- The federal government is using funding levers to maintain the basic system, and to develop national policies, structures and frameworks to push the system and achieve reforms.
- More of the implementation “action” is at the provincial level - particularly relevant in Ontario with the provincial government’s major health transformation agenda – where the government will limit the growth in hospital funding and make investments in primary care and other community-based services.
- Health care providers must be accountable for results.
- E-health initiatives are increasingly seen as tools to improve the health care system for providers, patients, clients, and funders.
- Clients and families are more informed - information about health issues is more readily available – and expect a more central role in addressing their health issues.
- Both the federal and provincial governments are committing resources to support health promotion and prevention efforts, such as the work in schools across the province.

B. MENTAL HEALTH AND ADDICTIONS LANDSCAPE: BUILDING A TRUE SYSTEM

One in five Canadians will experience a mental illness in their lifetime and the remaining four will have a friend, family member or colleague who will - 12% suffer mild to severe impairment from anxiety disorder, 8% are affected by major depression, and 1% are affected by schizophrenia (Health Canada: A Report on Mental Illness in Canada, 2002). One in seven hospitalizations, and one-third of all days in hospital involve patients with a mental illness (Canadian Institute for Health Information: Hospital Mental Health Services in Canada 2002-2003, 2005). One out of every 10 Canadians aged 15 and over – about 2.6 million people – reported symptoms consistent with alcohol or illicit drug dependence in the last year, and 8% of youth between the ages of 15 and 24 reported being affected by an alcohol or illicit drug dependency (Statistics Canada: Canadian Community Health Survey: Mental Health and Well-being, 2003). In Ontario, one quarter of cancer deaths – more than 5,000 deaths each year – are due to tobacco. Studies from the mid-1990s indicate that smoking costs the Province of Ontario \$3.7 billion, or almost 1% of the GDP, including \$1.1 billion in direct health care costs (Cancer Care Ontario Tobacco Facts). Only one third of Canadians experiencing feelings and symptoms consistent with a surveyed mental disorder or substance dependence sought help from a health care professional. About 21% of individuals with any of the surveyed mental disorders or substance dependencies reported feeling they needed help for their emotions, mental health or use of alcohol or drugs, but did not receive it during the 12 months prior to the interview (Statistics Canada: Canadian Community Health Survey, 2003).

There have been numerous reports documenting the need for reform within the mental health and addictions system – and successive attempts to reform the system. Current developments and

⁷ See: www.ehealthontario.ca

transformations within the broader health care system present an opportunity to bring about necessary changes within the mental health and addictions system.

KIRBY COMMISSION ON MENTAL ILLNESS, MENTAL HEALTH AND ADDICTION:

“Action for System Change”

The Kirby Commission has been studying mental health issues since the spring of 2003 as a follow-up to its report on the role of the federal government in health care in Canada. The Commission published its interim report in November 2004. CAMH provided input to the interim report through a CAMH position paper submitted to the Standing Senate Committee (June 2003) and a presentation by CAMH’s President and CEO, as chair of the OHA Mental Health Working Group (March 2004). Five priorities for action were recommended to the Senate Committee: (i) investments in community-based mental health care services; (ii) integration and continuity of care; (iii) development of a National Strategy on Mental Health; (iv) national standards in education, research, and development; and (v) the mental health care needs of Aboriginals.

The Kirby Commission interim report advocated for patient/client-centred care with a focus on recovery, including culturally appropriate services and supports – especially given the increasingly diverse nature of our communities – personalized care plans, system coordination and integration, community-based delivery, early detection and intervention, and enhanced access. The interim report paid special attention to the needs of children and adolescents, Aboriginal peoples, seniors, and individuals with complex needs. The report profiled the need for human resources planning in the mental health and addictions sector, and recognition of the critical roles that primary health care and community support workers, police officers and caregivers play. The report also focused on the workplace as an important setting for addressing mental illness and addictions issues. In particular, the report viewed employers as playing a vital role in dealing with mental illness and addiction among workers in terms of disability management, accommodation policy and return-to-work programs.

Expert witnesses⁸ to the Kirby Commission argued that funding dedicated to research into mental health, mental illness and addiction does not reflect the burden of mental illness and substance use disorders on the Canadian economy. The Canadian Institute of Health Research (CIHR), through its Institute of Neurosciences, Mental Health and Addiction (INMHA), is the primary federal funding agency for research into mental health, mental illness and addiction. Estimates suggest that if funding were to be provided in relation to the economic burden of disease, then CIHR’s support for mental illness and addiction would have to increase from \$33 million (2003-04) to at least \$80 million per year. The Kirby Commission was also told that CIHR’s proportional investment in mental health, mental illness and addiction (5.3%) is low in comparison to other countries (6.5% in the U.K., and 10% in the U.S.A.).⁹

Since issuing its interim report, the Kirby Commission has held public hearings throughout the country, and has received position papers and letters in response to questions presented in the interim report. CAMH’s President and CEO presented to the Commission in February 2005 - again representing the OHA Mental Health Working Group. In this submission, the OHA commended the Senate Committee for the in-depth review and identification of issues within the mental health, mental illness and addiction sector within Canada, and advocated for two key elements to be included in a national action plan – research and development, and data collection and information systems (including a specific recommendation that the Resident Assessment Instrument – Mental Health [RAI-MH] be the primary mental health and addiction information system for Canada; see discussion below regarding the RAI-MH). CAMH submitted specific responses to questions and options raised in the interim report in the

⁸ Including CAMH’s Vice President of Research who submitted a report to the Kirby Commission.

⁹ “*Mental Health, Mental Illness and Addiction: Issues and Options for Canada*”. Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology. November 2004.

¹⁰ “*Vision and Strategic Directions for Research: A Report on the Internal Focus Group Discussions, CAMH*”. Innovation Institute of Ontario, July 7th, 2005 (draft).

Fall 2005. Recently, Senator Kirby's Standing Committee proposed the creation of a Canadian Mental Health Commission to move long-neglected mental health issues into the mainstream through initiatives such as a national Knowledge Exchange Centre and anti-stigma campaign.

CAMH has been providing advice and support to Senator Kirby and his Commission, and will have an important role to play in the implementation of the final recommendations of the Kirby Commission.

NATIONAL MENTAL HEALTH FRAMEWORK:

There has been a lot of discussion and some groundwork on the part of the federal government and provincial organizations in preparation for developing a national framework for mental health. CAMH and the OHA have advocated strongly for the development of a national action plan on mental health. It is possible that the Kirby Commission final report will serve as a catalyst for launching a national mental health framework. As well, the recent announcement by the federal government of its appointment of the Honourable Michael Wilson as special ministerial advisor on mental health and the workplace could be rolled into future plans to develop a national framework.

NATIONAL FRAMEWORK FOR ACTION ON SUBSTANCE USE AND ABUSE IN CANADA:

Health Canada (HC) and the Canadian Centre on Substance Abuse (CCSA) has provided leadership in the development of a National Framework for Action on Substance Use and Abuse in Canada, and recently co-hosted a national forum to solicit feedback on the vision, principles, objectives and priorities for a national framework (June 2005). Specific feedback on revisions to the evolving framework was provided, as well as strong support for the continued leadership of HC and CCSA. Partners in the development and implementation of the national framework include: the federal government, provincial and territorial departments and agencies, municipalities, non-governmental organizations, Aboriginal communities, communities of interest, and the private sector. Next steps include continued participation in thematic workshops that will address specific priority issues identified in the national framework; and endorsement of the national framework from stakeholder governing bodies (including CAMH). Priorities for 2006 include the adoption of a specific and long-term governance model.

As part of the federal government's commitment to addressing substance use and abuse issues, it has signed Memorandum of Understandings with seven provinces for the development of Health, Education, and Enforcement Partnerships (HEP). In Ontario, CAMH is partnering with CCSA, the Ontario Association of Chiefs of Police, and the RCMP to develop a provincial HEP network and a provincial drug strategy. This federal / provincial / territorial initiative is intended to evolve with a focus on evidence-based approaches and a respect for the diverse needs of the provinces and territories.

INSTITUTE OF NEUROSCIENCES, MENTAL HEALTH AND ADDICTIONS (INMHA) – RESEARCH FUNDING:

There has been general buoyancy in the Canadian research environment over the last few years. Research funding from the Canadian Institute of Health Research (CIHR) – the federal grant-funding body – has nearly doubled in the last ten years. The announcement of the Canada Research Chairs program and the Canada Foundation for Innovation has provided salary awards and research infrastructure to research organizations – like CAMH – to enhance research infrastructure and attract internationally renowned scientists. However, the research environment is becoming increasingly competitive given the increasing cost of science and the levelling off of resources.¹⁰

The Institute of Neurosciences, Mental Health and Addictions (INMHA) – one of thirteen Institutes of the CIHR - is currently in the process of developing its second strategic plan for 2006-2011. INMHA has collaborated closely with the Kirby Commission on behalf of CIHR. In order to inform its strategic plan, and to identify major challenges and innovative strategies from a research perspective for the Kirby Commission, INMHA issued a request for stakeholder input on a national strategy for research in mental health and addiction in Canada. CAMH articulated recommendations for enhancing mental health and addictions research in its submission to the Kirby Commission – *Translating Discoveries*

into Care – Enhancing Research in Mental Illness and Addictions – and will build on this document in responding to the CIHI request for input.

PROVINCIAL GOVERNMENT ANNOUNCEMENTS – ENHANCING COMMUNITY-BASED SERVICES:

The May 2005 provincial budget announcement included the following:

- Investment of \$185 million over four years (to 2007-08) to expand the mental health system and stabilize existing services (i.e., case management, counseling, crisis response, early intervention, assertive community treatment teams, supportive housing) for almost 79,000 more individuals in need of mental health services in the community - this was the second consecutive annual investment in this sector by the provincial government.
 - In 2004-05 more than 13,600 people gained access to community based mental health services;
 - In 2005-06, \$58.3 million will be invested to expand community mental health services for almost 34,000 additional mental health patients in their communities (News Release, July 2005).
- An enhanced Canada-Ontario Affordable Housing Program that will help create over 15,000 new units of affordable housing, including new housing for people with mental illness.
- Continued allocation of 2% of gross slot machine revenue, estimated at \$36 million for 2005-06, to programs that support problem gambling and related treatment, prevention and research programs. (There is some speculation that the language allows for the resources to be used more broadly across the addictions sector.)

Enhanced community-based services will require more effective integration and partnerships between hospital and community providers. It is interesting to note that in a recent survey of Ontario acute care hospital CEOs (January 2004) only 2.9% reported partnerships with mental health facilities, compared to reported partnerships with rehabilitation facilities (34%), complex continuing care facilities (37%), long term care facilities (54%), primary care providers (59%), and community care access centres (61%).¹¹

DIVESTMENT OF PROVINCIAL PSYCHIATRIC HOSPITALS:

The Whitby and North Bay psychiatric hospitals are scheduled to be divested in 2005. It is not clear at this time whether there are any plans to divest Penetanguishene, the remaining provincial psychiatric hospital (PPH). Divestment has highlighted how much the psychiatric system has been neglected over the years. For example, divestment of the Queen Street site highlighted the need for capital investments and the need for alignment of staff compensation. It has been suggested by some observers that there is a propensity for mental health services to be diluted in a divested system.

The CAP (Community Comprehensive Assessment Projects) data suggests that some groups of clients are being under served and others are being over served.¹² The shift away from PPH care for clients with serious mental illness is evident by the large number of clients being served in the community mental health system. PPH inpatient and outpatient programs continue to serve a more disabled population of clients compared to the community mental health system, although the CAP

¹¹ “Acute Care Hospitals Strategic Priorities: Perceptions of Challenges, Control, Competition and Collaboration in Ontario’s Evolving Healthcare System”. *Healthcare Quarterly*. Vol. 8 No. 3. 2005.

¹² “Mental Health Services in Ontario: How well is the province meeting the needs of persons with serious mental illness?” Koegl, C., Durbin, J., and Goering, P. (2004). The Health Systems Research and Consulting Unit, CAMH.

¹³ “Addressing the Burden from Alcohol with a Harm Reduction Perspective on Retailing”. Presentation to the Expert Panel to Review the Sale and Distribution of Beverage Alcohol in Ontario. CAMH. February 25th, 2005

¹⁴ The Strategy-Focused Organization. Robert S. Kaplan, David P. Norton. Harvard Business School Press, September 2000.

data demonstrate that many of the PPH inpatients could be served in the community if more services and supports were available there. The ability of PPH to discharge patients to less restrictive environments is restricted by the lack of system capacity to provide intensive community support, leaving many individuals in the community with inadequate support. Assertive community treatment (ACT) services need to explore strategies for transferring higher functioning clients into lower levels of care so that more disabled clients can access this specialized service.

FORENSIC MENTAL HEALTH SYSTEM IN ONTARIO:

Demands in the forensic mental health system have seen steady increases over the last number of years. Adding to these increasing demands, recent court decisions have ruled that it is a violation of a person's Charter rights to be jailed if they have been ordered by a court for an inpatient psychiatric assessment, or detained in a higher level of security if they have been ordered by the Ontario Review Board (ORB) to lower levels of security. Historically, individuals in either of these two cases have been detained in jail for up to 30 days until an appropriate bed was available and then transferred. As of May 2005, courts are sending individuals ordered for assessment to hospitals "forthwith" without consulting with regard to bed availability, resulting in intense pressure on hospitals and the community housing sector. Hospitals are at risk as they have a limited capacity to appropriately and safely accommodate forensic assessments, and provide appropriately secure bed units. Community housing providers are challenged to provide suitable housing for clients with community treatment/housing orders (based on ORB decisions) – i.e., the community housing sector does not have the capacity to appropriately accommodate many clients who require higher levels of supervision and support. The impact for CAMH has been that it gets more than its "fair share" of ORB clients – CAMH serves 25% of all ORB patients in the province, with 17% of the province's bed resources. Another complicating factor in the forensic mental health system is that significant inter-ministerial cooperation between the Attorney General, Community Safety and Correctional Services, Municipal Affairs and Housing, Community and Social Services is required. Leadership, resources and meaningful participation of hospital and other community stakeholders are required to develop and implement a forensic mental health system that includes sufficient and appropriately secure beds, expanded community housing for clients with higher supervision and support needs, and expansion of forensic outpatient services. The demand for forensic mental health services on CAMH is likely to continue to grow. CAMH will need to make strategic decisions regarding its response to pressures in the system and the role it plays – leadership role, partnership role with community providers, etc. - in coordinating with and developing the forensic mental health system in Ontario.

PROVINCIAL GOVERNMENT LEGISLATION, POLICY INITIATIVES:

In addition to the *Commitment to the Future of Medicare Act, 2004*, as discussed above, the following legislation was passed and policy reviews undertaken by the provincial government.

Smoke-Free Ontario Act. The Act was passed on June 8th, 2005. CAMH made a submission to the Standing Committee on Finance and Economic Affairs in April 2005 advocating for a comprehensive tobacco control strategy including prevention, protection and cessation goals, an increase in tobacco taxes, provincial smoke-free legislation with no exemptions, funding for smoking cessation and reduction interventions; funding for public education campaigns, legislation that eliminates cigarette displays and requires plain packaging. CAMH also offered to serve as a resource to government as it proceeds with the implementation of this legislation.

Beverage Alcohol System Review Panel: This Review Panel was established by the provincial government in January 2005 with a mandate to review the sale and distribution of alcohol in Ontario. CAMH lobbied for the expansion of the membership of the panel to include public health representatives. CAMH also made a submission to the panel, presenting scientific evidence to support its position that the government should maintain and strengthen the control system as a means of preventing alcohol-related problems, and that the retail distribution of alcohol should be under monopoly control.¹³ The Panel released its report on July 18th recommending that the provincial government auction off control over the retail and wholesale distribution of alcohol. The provincial

government rejected the major recommendation of the panel – the government is committed to continued public ownership of the LCBO (News Release - July 18th, 2005). CAMH responded to this decision by publicly supporting the government's decision and offering information and expert sources to the media.

Review of the Gaming Industry in Ontario: The provincial government is conducting an operational review of the gaming industry and the role of the Ontario Lottery and Gaming Corporation. CAMH congratulated the Ministers of Economic Development and Trade, and Health and Long Term Care for undertaking the review and including problem gambling as part of the review. CAMH has used research evidence to argue – through various avenues – that expansion of gambling represents a significant public health concern. CAMH has requested an opportunity to participate in the review process, and advocated for the adoption of a harm reduction approach that addresses the underlying risk factors for problem gambling (social, behavioural, economic, political) and utilizes coordinated health promotion strategies involving policy, individual and community based interventions.

Child and Youth Mental Health Policy Framework: The Ministry of Children and Youth Services (MCYS) is committed to developing a provincial Child and Youth Mental Health Policy Framework to guide improvements of the current service system within existing resources and set the course for any future service enhancements within the sector. A background document was released in August 2005 and is intended to guide the process for MCYS to solicit the views of youth, families, service providers, clinical and professional practitioners, voluntary organizations and other interested parties regarding its vision, beliefs, principles and policy goals for the child and youth mental health services sector in Ontario. Stakeholders were invited to submit written responses to MCYS by November 2005, which CAMH has done. A policy framework is to be completed by the winter 2006, and an action plan prepared by the summer 2006.

MENTAL HEALTH CARE – PROVINCIAL ACCOUNTABILITY TOOLS:

Hospital Report Cards for Adult Inpatient Mental Health Care: The OHA and MOHLTC released the second Hospital Report for adult inpatient mental health care in the spring of 2005, reporting on 24 indicators using Kaplan and Norton's balanced scorecard framework.¹⁴ All future versions of the OHA Report Cards will be e-scorecards, providing additional capabilities for analysis and comparisons. "Overall, results indicate many strengths in delivery of inpatient mental health care, consistent with the values of mental health reform."¹⁵ Areas identified for improvement include: issues around targeted and appropriate use of inpatient services (alternate level of care, average length of stay, readmissions, and community capacity to serve individuals with higher care needs); integration and post-discharge care (need for continuum of community supports, implementation of EHR); evidence-based practice (need for benchmark facilities and programs to be identified, implementation of standardized, evidence-based approaches for delivering care); consumer-centred care (adoption of practices to enhance consumer participation); and system development to support ongoing monitoring (use of performance expectations). CAMH had mixed results in the provincial scorecard and continues to monitor performance internally with its own balanced scorecard (BSC). Adopting the most recent best practices in this field, the BSC is being modified to address the specific needs of individual target audiences. The first version of the Corporate Level Scorecard was released in July 2005, and work continues in the development of Clinical scorecards.

Resident Assessment Instrument for Mental Health (RAI – MH): The MOHLTC has mandated all hospitals to use the RAI – MH assessment tool for all inpatients in designated psychiatric beds in Ontario, effective October 1, 2005. The RAI-MH is a standardized, multi-dimensional, interdisciplinary assessment instrument that produces care planning protocols; rating scales and quality indicators; outcome measurements; and produces case weights that the MOHLTC will eventually use for funding purposes. CAMH has taken a leadership role in the province as an early adopter of the RAI-MH.

¹⁵ Hospital Report 2004, Mental Health. E. Lin, J. Durbin, et al. Joint Initiative of the Ontario Hospital Association and the Government of Ontario, 2005.

Implementation continues to take considerable resources, and with the future dependence on this information for funding purposes, the organization will continue to research the use and applications of the information, and address data quality and compliance issues.

Common Data Set for Mental Health (CDS – MH): The MOHLTC recently introduced the CDS-MH as additional clinical information to be submitted annually for outpatient community mental health programs in order to address issues around desired outcomes for mental health reform and appropriate levels of government spending in community mental health. The expectation is that this will provide the MOHLTC with the basic data for community mental health accountability for funding already provided. The basic minimum data set is aggregate data, but it is expected that future data collection requirements will be expanded to accommodate specific service recipient level reporting in order to develop case mix groups and case weights that will eventually assist in the provision of equitable funding for the sector. These plans will require additional technology and infrastructure to allow for the more detailed data collection. Opportunities such as the Resident Assessment Instrument for Community Mental Health (RAI-CMH) and the Resident Assessment Instrument for Emergency Screening (RAI-ESP) may provide the additional information required to measure resource utilization in the field. CAMH is required to submit the CDS-MH data, and is participating in several research projects for further development of the RAI-CMH and RAI-ESP.

TORONTO DRUG STRATEGY:

“Intersectoral collaboration to support implementation”

In January 2004, the City of Toronto/Toronto Public Health brought together key partners and stakeholders to develop a comprehensive drug strategy based on the four key areas of prevention, treatment, harm reduction, and enforcement. The comprehensive drug strategy is intended to set common directions and priorities, share knowledge and best practices, clarify roles and responsibilities, ensure accountability, and identify concrete actions for intersectoral collaboration. CAMH participated in the development of the Toronto Drug Strategy through senior level representation on the Strategic Management Team and representation on the Community Reference Group. CAMH background papers and research contributed to a scientific basis for the strategy.

A report to City Council, with recommendations to implement a Toronto Drug Strategy, was released on October 14th, 2005. The Strategy includes a policy approach, vision statement, guiding principles, and 66 recommended actions organized by key themes – leadership and coordination; children and families; youth; people who use substances; neighbourhoods and communities; awareness, education and training; research and evaluation. The key recommendation is to establish a Toronto Drug Strategy Implementation Committee, which is expected to provide a progress report to City Council within 18 months of its inception. As a key partner in the development of this strategy, CAMH will collaborate to support its implementation, including participation on the implementation committee, and providing supports through its education and health promotion efforts and its treatment programs.

MENTAL HEALTH / ADDICTIONS EMERGENCY RESPONSE (ER) ALLIANCE:

The ER Alliance is a partnership among five hospitals within the GTA – CAMH, St. Joseph’s Health Centre, St. Michael’s Hospital, the University Health Network, and Mount Sinai Hospital – who are working together to address the need for better access and quality of care for people experiencing a mental health or addiction emergency. The ER Alliance aims to: improve access to emergency care through redistribution of mental health / addictions patient volume to general hospital sites; and (ii) ensure ongoing utilization of best practice emergency treatment and the development of a centre of excellence in emergency mental health / addictions care. Key deliverables of the Alliance include: improved client care; improved cost efficiency; enhanced partnerships; fulfillment of the MOHLTC mandate that CAMH focus on tertiary care and specialty services; and implementation of the CAMH Functional Plan (i.e., CAMH will fulfill its tertiary role by providing access to specialty beds and consultation for the treatment of complex patients). Emerging data within health care demonstrates the cost efficiency of strategic alliances, along with improved patient care and system level benefits.

The ER Alliance model is similar to models used for treatment of stroke, trauma and burn victims, and is consistent with the direction of the LHINS. The ER Alliance has received support from the Toronto Academic Health Sciences Network (TAHSN).

The ER Alliance partners are currently developing a business case for the establishment of three comprehensive mental health / addictions emergency care sites - at St. Joseph's Health Centre, St. Michael's Hospital, and the University Health Network (in response to the MOHLTC position that one site is sufficient). The business case positions CAMH and Mount Sinai Hospital as the providers of tertiary care and specialty consultation (e.g., first episode). The business case will include requests for capital renovations and operating resources. It is anticipated that it will be submitted to the MOHLTC by late October 2005.

CLOSING OF WITHDRAWAL MANAGEMENT SERVICES BEDS:

The MOHLTC and the Toronto Withdrawal Management Sector instructed CAMH to close its 501 Withdrawal Management Service (501 Queen Street West) as of August 31, 2005. The closure is part of an overall plan approved by the MOHLTC to move the present in-patient (bedded) system within the Withdrawal Management Sector to one that is made up of both bedded and outpatient (non bedded) services. The need to create a more efficient and diverse system with a wider range of choices for clients rather than bedded services only is the primary reason behind the new plan. CAMH is collaborating with the withdrawal management sector to minimize service disruption and to provide transitional care for clients. As an active participant of the Toronto Withdrawal Management Transition Steering Committee (which is made up of hospitals involved in this sector transition), CAMH remains committed to working within the sector and playing a role in future concurrent disorders capacity building, research and evaluation, and will continue to offer medical withdrawal management bedded services at the Brentcliffe site.

OTHER FACTORS – CITY OF TORONTO:

Homelessness: Homelessness issues continue to be serious in the City of Toronto despite an infusion of funding from all levels of government. The link between mental health and addictions issues and homelessness has been noted, but an expanded and more effective system for addressing the needs of people who are homeless as a result of mental health and addiction is required. CAMH will need to make strategic decisions regarding the role it plays, along with community mental health and addictions service providers – and whether it takes a leadership role – in advocating for and providing better housing supports for clients.

Public Health: Given the experience that the City of Toronto experienced during the SARS crisis, there is a renewed appreciation for the critical role that public health initiatives can play in ensuring a safe and secure environment.

EMERGING TRENDS, ISSUES:

Determinants of Health: There has been an increasing recognition of the social determinants of health. At the federal level, the Minister of State (Public Health) Carolyn Bennett is spearheading an extensive public consultation on public health goals that address “broader determinants of health, such as poverty, violence, environment, shelter, education and equity”.¹⁶ The Minister of State has also enhanced Canada's presence on the international population-health scene by her support of the World Health Organization's Commission of the Social Determinants of Health and the European Strategy for Public Health. At the provincial level, establishment of the Ministry of Health Promotion provides a potential opportunity for increased emphasis on healthy public policy to address underlying factors that influence health, illness and social problems. Addressing determinants of health such as

¹⁶ News release – Public Health Agency of Canada. July 22nd, 2005.

income, housing, education, social supports, etc. will require cross-ministry and multi-sector collaboration.

Recovery Goals: Recovery goals in mental health and addictions have been building momentum internationally, provincially and locally.¹⁷ In the U.S., the Substance Abuse and Mental Health Services Administration (SAMHSA) has been developing recovery-oriented policies, programs, tool kits, and conducting outcome research. In Ontario, the Provincial Forum of Mental Health Implementation Task Force Chairs articulated a recovery philosophy as an integral tenet of a reformed mental health system. CMHA-Ontario, in its *Recovery Rediscovered* (2003) document, emphasized that a fundamental alteration in how mental health services are delivered is needed. At a community level, there are numerous recovery initiatives across the province. In *Making Recovery Come Alive at CAMH* (draft - June 2005), it was proposed that “a person begin recovery when he or she has hope for a full life, defines him or herself as an individual, not an illness, feels empowered to make decisions in his or her own best interest, takes responsibility for self management, and finds personal meaning”. There is a consistency of philosophy between recovery goals and principles and strategies of health promotion – one of CAMH’s key mandates.

Client and Family Empowerment, and Consumer Advocacy: In the hospital sector, patient/client and family-centred care – which views patients and families as partners in the care process - is gaining momentum. Principles in client and family-centred care include: treating clients and families with dignity and respect, sharing information with clients and families, enabling client and family participation and collaboration in care decisions. This approach to care enhances the experience of clients and families and benefits the practice of health professionals.¹⁸ In the mental health area, consumer/survivor initiatives - including self-help, peer support, consumer advocacy – are increasingly viewed as playing a critical role in easing and enabling people’s transition from formal mental health services back into the community. These initiatives view people with mental illness, and their families, as having important experience and knowledge that is critical to understanding prevention, treatment and recovery. Because people with mental illness are particularly vulnerable it is important that mechanisms for consumer decision-making, choice and participation are protected.¹⁹

Increasing Diversity: Ontario takes in the largest share of newcomers to Canada – over 50% of all new immigrants. In Toronto, 49% of the city’s population was born outside of Canada of which half are new immigrants (i.e., 23% arrived between 1996 and 2001). It will be critical for CAMH to maintain a strong focus on determining the unique needs of newcomer communities and attempting to meet those needs. Toronto is diverse in many other ways as well - population growth amongst seniors and youth, increasing levels of poverty, strong religious and spiritual diversity, increased activism and profile related to sexual orientation, and ethnoracial visibility. The implications of this for our city and our province on service delivery – in the health care system in general, and the mental health and addictions world in particular – are profound. For CAMH, we must be able to ensure responsive, comprehensive culturally competent service delivery that reflects this reality.

Pharmacotherapies: New pharmacotherapies are being approved in other jurisdictions and, in some cases, are proving their therapeutic value. The availability of new pharmacotherapies will take some time in Canada given the requirements of the drug approval process. It would be important to determine the likelihood of new pharmacotherapies being approved for use within this next strategic planning cycle (2006-09).

¹⁷ See “Making Recovery Come Alive at CAMH” (Draft – June 2005) for a full description of recovery goals.

¹⁸ Patient and Family-Centered Care: Strategies for Leadership. Sponsored by the American Hospital Association and the Institute for Family-Centered Care.

¹⁹ Consumer / Survivor Initiatives: Impact, Outcomes, Effectiveness. CMHA-Ontario, CAMH, Ontario Peer Development Initiative, and OFCMHAP.

Addictive Behaviours: Despite significant advocacy on the part of CAMH and addiction focused organizations, addictive behaviour continues to be viewed as less “deserving” of public policy or financial support. It is important that CAMH, and its partners, continue to be vigilante in advocating for a continuum of services for those people suffering from addictions. Recently, there has been significant media attention on the issue of problem gambling and the gaming industry (i.e., the substantial revenue that the government receives, actual and anticipated growth in the industry, social/health/economic impacts, etc.). Similarly, there are emerging concerns about the health impact of video games on children and young people. The public policy decision to use 2% of revenue generated in the gaming industry to support services for people who experience problems with their gambling is increasingly viewed as a good model that could be applied to other addictions – i.e., the impact that 2% of alcohol sales could have on the delivery of services and supports for people who misuse or abuse alcohol would be significant.

SUMMARY:

- Clients and families are informed and want to be equal partners in decisions about their care and services.
- In Ontario, the mental health and addictions sector is coming together – increasingly, the sector is speaking with one voice. However, there are some challenges to overcome.
- The provincial government has made a commitment to enhancing community-based care and services.
- It is increasingly critical for community providers and the hospital sector to work together in an integrated way, and to clarify their respective roles and responsibilities. Services provided by both community providers and hospitals are necessary for the delivery of a continuum of services and to ensure a strong voice from the mental health sector. CAMH has an important role to play in bridging between these two components of the sector together given its experience in working effectively with both hospitals and the community.
- CAMH and partners have been effective in gaining recognition for mental health and addiction issues at the LHIN level - this recognition needs to continue to be enhanced; and CAMH and the sector need to focus on other transformation priorities to ensure the same prominence for mental health and addiction issues.
- The forensic mental health system in Ontario is under pressure during this period of evolution.
- At the federal, provincial and municipal levels there is an increased focus on health promotion and disease prevention. Investments are being made in integrated and collaborative approaches to address the needs of people across the health continuum – from healthy to high-risk people to people living with chronic diseases.
- Intersectoral partnerships - health, social services, education, children’s services, justice, etc. - are increasingly the expected mode for developing and implementing strategies, frameworks and services. Enhanced capacity at various levels is expected to contribute to stronger public policies and more integrated, evidence-based and responsive health systems.
- CAMH needs to broaden its partnerships – increase collaboration with other teaching hospitals, and more broadly, increase collaboration across the sector and with other sectors in response to the increasing expectation for intersectoral collaboration.
- CAMH, and its partners, need to continue to be vigilante in advocating for a continuum of services to address addictive behaviours – collaboration with key organizations from across the country to implement a National Framework for Action on Substance Use and Abuse is required.
- The final report of the Kirby Commission may serve as a catalyst for development of a national mental health framework. CAMH needs to keep focus on opportunities to influence the development and implementation of a national initiative.

C. CAMH: GOING FORWARD IN A TRANSFORMING HEALTH SYSTEM

The key mandates of CAMH – care, research, education, health promotion, and public policy – will continue to serve as the pillars of our work as we move into our third strategic planning cycle. This section of the paper will provide a brief summary of a selection of initiatives in client care, research,

health promotion, public policy and system reform, as well as some corporate “enabling” initiatives where CAMH has built expertise and capacity over 2003-06.

IMPROVING AND TRANSFORMING CARE:

Functional Program Implementation / Redevelopment:

There is widespread support for CAMH's Functional Program as its implementation will further improve client care, eliminate silos between programs, and enhance access to integrated service that includes a range of programs and a range of clinical supports (e.g., IPCC, team of care professionals, additional supports). Implementation of the Functional Plan is intimately linked to the redevelopment of the Queen Street site, resulting in the consolidation of core programs at the Queen Street site and the creation of a hub and satellite model for programs in support of the needs of patients throughout Ontario. Following up on a \$16 million redevelopment planning grant, the provincial government announced on September 9th, 2005 a major investment to support phase 1 of the multi-phased redevelopment project. Phase 1A will be a traditionally grant-funded project with construction of the Alternative Milieu bed project set to begin in fall 2006. Phase 1B – the core bed buildings and the outpatient care buildings - will be financed through an Alternative Financing and Procurement (AFP) vehicle, with construction initiated in 2008-2009.²⁰ As redevelopment proceeds, there is some concern that the magnitude and gravity of the change, and the implications for day-to-day service delivery with our clients has yet to be fully appreciated (i.e., the logistics required to support smooth transition during the physical move to new locations are significant). On the other hand, there is also the recognition that realization of our goals for improved service access and integration will not be fully realized until programs and services are co-located at the redeveloped Queen Street site (i.e., the current geography of program delivery is not conducive to service connections and integration).

Bill of Client Rights:

CAMH and the Empowerment Council launched the Bill of Client Rights in April 2005. The Bill upholds the dignity and worth of all clients first and foremost through the practice and acknowledgement of client rights. The Bill of Client Rights – created by the clients of CAMH - is strongly endorsed by both the CAMH Board of Trustees and the Empowerment Council Board. The Bill articulates an exceptional commitment to the rights of clients, and is considered to be the most meaningful and powerful one of its kind in Canada. Education for CAMH staff around the Bill is currently being rolled out, including an e-learning strategy.

Interdisciplinary Plan for Client Care (IPCC): The IPCC was created as a tool to be used when developing care plans with clients in all clinical programs at CAMH. The IPCC documents client goals and preferences, including goals for the broad determinants of health – housing, employment, income security, education, family support, social networks, etc. The tool aids communication among caregivers and supports coordination of care as clients move through services at CAMH and in the community. Customized training for clinical staff in the use of the IPCC has been completed (1200 staff trained). A plan for ongoing training for new clinical staff has been developed. Program audits are conducted to ensure that all new admissions use the IPCC tool. Pilot planning for an electronic IPCC is in process. Partnerships have been established with the Client Employment Initiative, the Family Initiative, the Recovery Initiative and the Health Promotion Team to ensure that health promotion principles and strategies are integrated into IPCC training.

Family-Centred Care:

A steering committee with representatives from the Family Council, the Community Support and Research Unit (CSRU), family members, and representatives from each of the clinical programs has

²⁰ Funded through the Ministry of Public Infrastructure Renewal, construction of the majority of the redevelopment will be financed and carried out by the private sector which will assume the financial risks if the project is not finished on time and on budget. The completed facility will be publicly owned, controlled and accountable.

continued to guide the Family-Centred Care (FCC) initiative. A toolkit, including a best practices document and a survey instrument to use with families, was developed as a resource for the clinical programs. 52 teams within all nine clinical programs have developed FCC action plans which define steps to: involve families in client care; enhance professional services to families; and support families in helping each other. The nine clinical programs have developed action plans for applying a FCC philosophy within their program. All team and program level plans were reviewed by representative staff and family members of the FCC steering committee and returned to directors with feedback for implementation. Subcommittees have begun work in the following areas: developing a training strategy for CAMH staff; staff recruitment; site redevelopment and current site design issues; and privacy issues. Work in these areas will address some of the barriers identified by teams and will involve collaboration with non-clinical departments. Efforts are being made to embed FCC into CAMH daily operations (e.g., the IPCC has included a section on families, some performance appraisals have been modified to include this topic). The steering committee has also begun collaboration with family-led organizations and other agencies and hospitals that are moving towards Family-Centred Care.

Cultural Competence:

A steering committee identified three priorities: (i) develop a background paper on clinical cultural competence (including best practices from the literature, and staff/client perspectives); (ii) develop a policy on alternative and complementary therapy; and (iii) promote initiatives aimed at translating the awareness and understanding of diversity into clinical initiatives, clinical skills, and clinical competencies. A task group of members from the steering committee and the Clinical Practice Council (CPC) was struck to develop a policy for alternative and complementary therapies at CAMH. A number of initiatives are underway with respect to translating awareness of culture and diversity into clinical care. A curriculum for *Clinical Cultural Competence – Diversity Level II* training – has been developed in collaboration with an interdisciplinary staff team; staff training plans and implementation of the curriculum are under refinement. The discipline chiefs (through CPC) have begun discussions regarding discipline specific perspectives on clinical cultural competence - these will be developed further to determine the professional practice standard for CAMH. External funding (\$100,000) from the Change Foundation's Nursing Innovations Program has been received for a two-year project aimed at assisting nursing staff to develop competencies in culturally responsive therapeutic relationships – recruitment of participants will commence in September 2005. This is a partnership with the Faculty of Nursing, University of Toronto, and the Pacific Institute for Research and Evaluation. The project is aimed at capacity building with nursing staff, but will also lead to the development of an internet-based tool to foster critical reflection in practice.

Consultation, Assessment, Triage & Support Program (CATS) - Emergency Response (ER) Alliance:

A key implementation task of the Functional Program is the establishment of CATS. The team of liaison clinicians that supports CATS help to guide new clients through the array of emergency, assessment and short-term follow-up services. Depending on individual needs, a new client may be referred to one or more of CAMH's specialized programs or linked to a community agency. The ER Hospital Alliance has been established - 5 hospitals working together to ensure better access and quality of care for people experiencing mental health or addictions emergencies – and a business case for the partnership is under development. The implementation of CATS has resulted in increased utilization and availability of assessment and follow-up services. CATS has implemented a new clinical database (CCTS) that efficiently tracks referral numbers, consult numbers, wait times, connections with CAMH specialty programs, as well as providing a scheduling tool. A specialized psychiatrist has been hired to provide culturally competent clinical assessments, education and training to all clinical staff: CATS is reaching out to the Tamil, Chinese, and French speaking communities to increase access to mental health assessments and improve quality of care; and CATS is building on CAMH's Diversity Training Level 1 to increase clinicians' confidence in cross-cultural practice. CATS has taken steps to improve work with families, developing a family action plan and providing clinicians with training regarding working effectively with families. In the Fall 2005, CATS and Policy, Education and Health Promotion (PEHP), in collaboration with the University of Toronto Psychiatric Outreach Program (UTPOP) will implement a 6-month pilot of a Mental Health Clinical Consultation Service that will provide telephone support to family doctors in target locations in Ontario regarding mental health assessment and treatment. These target locations will include approximately

1000 family doctors from North East and North West LHIN Regions of Ontario and approximately 150 medical doctors from selected Family Health Networks in Toronto.

Early Intervention:

CAMH is a key member of the Ontario Working Group on Early Intervention in Psychosis, which has successfully advocated for the establishment of early intervention (E.I.) as a provincial government priority – the government announced a \$4.5 million commitment to E.I. in 2004, with a further commitment of \$8.1 million in a July 2005 funding announcement. CAMH programs that have received E.I. funding are the LEARN Centre, FACT (Peel), and the Mood and Anxiety Disorders Program. As well, CAMH has contributed to the MOHLTC's policy framework for E.I., which was released in January 2005. In March 2005, CAMH took a leadership role in hosting a provincial workshop for all E.I. funded programs, and in developing an E.I. information toolkit. A survey of the training needs of E.I. programs across the province has also been completed. A report will be completed in Fall 2005. A partnership between CMHA Toronto has been established to support the roll-out of E.I. in Toronto. Through this partnership, work is underway to establish a Toronto Early Psychosis Network with multiple stakeholders – CAMH co-chaired the first network meeting in July 2005. There are a number of initiatives to ensure that the kind of leadership for E.I. demonstrated by the Schizophrenia program is extended to other programs - e.g., Geriatric Mental Health program, including a strategy for E.I. in ethno-racial populations; the Addictions program; the Concurrent Disorders program; the Mood and Anxiety program; and CSRU, which has been funded through the Ontario Mental Health Foundation (OMHF) for a research project which will lead to recommendations for integrating E.I. in primary care – recommendations are expected in Fall 2005.

Clinical Health Promotion:

CAMH's Health Promotion Team provided a series of consultations and training opportunities for clinical program staff with the goal of increasing health promotion principles and strategies in clinical practice. Approximately 100 clinical staff from three different programs participated in the training. A survey assessing clinical program leaders' health promotion knowledge and understanding found a significant increase in awareness of health promotion concepts between 2003 (the baseline survey found a 56% awareness level) and 2004 (74% awareness level). An inventory of health promotion initiatives in the clinical programs was undertaken in 2002 and updated in 2004 – the number of health promotion initiatives increased by 68% during the two years. A *CAMH Clinical Health Promotion Inventory and Resource Guide* will be distributed to CAMH Clinical Programs in the Fall 2005. Of particular interest for CAMH, is the May 2005 release of "Health Promotion in Hospitals: Evidence and Quality Management" by the WHO's European Office (www.euro.who.int/document/E86220.pdf). Over a decade after launching its Health Promoting Hospitals project – which was initiated to encourage hospitals to place greater emphasis on health promotion and disease prevention, rather than on diagnostic and curative services alone – this resource summarizes the evidence base for health promotion in hospitals, profiles strategies and standards, and discusses the application of the balanced scorecard and quality management models to health promoting hospitals. CAMH has a strong record of implementing health promotion concepts into practice, and advocating for consideration of the determinants of health in policy and program initiatives.

Problem Gambling:

CAMH has served as a hub resource to the problem gambling system in Ontario by providing training to over 120 agencies. CAMH has developed educational materials for clients, families and service providers. Its community awareness training package has been successfully marketed in other provinces and countries. The Problem Gambling Service is the largest treatment provider for problem gamblers and their families in Ontario. Its focus includes diverse populations - it works in partnership with many ethno-specific agencies in the Toronto region to make prevention, identification and treatment available in community languages. CAMH is the lead resource conducting problem gambling research in Ontario and Canada, across the spectrum of biological, psychological and social domains. It has produced knowledge that is shaping how we understand, prevent and respond to gambling problems. The Journal of Gambling Issues (JGI) is published by CAMH, and has an on-line readership that includes 3,540 subscribers on every continent. CAMH is an active collaborator with provincial partners, currently working with treatment providers to set up four residential services for

problem gamblers, and taking the lead role in evaluating these initiatives. It has signed a memorandum of understanding, as have other provincial lead agencies, with the Ontario Lottery and Gaming Commission, to support the development of responsible gaming policies and practices and the enhancement of services for problem gamblers. A problem gambling website is currently under development and will contain a range of online resources and services that will be supportive of Ontario's problem gambling strategy. CAMH has initiated discussions with the MOHLTC about an Ontario Centre for Problem Gambling that would locate CAMH's problem gambling resources under one roof. CAMH will host a research day on problem gambling that will highlight past and current accomplishments and encourage new collaborative activities (Winter 06).

Concurrent Disorders:

The Concurrent Disorders Service (CDS) has developed a reputation for working effectively with clients with complex problems.

- Dialectical Behaviour Therapy Clinic won a major research award to study suicide interventions for people with borderline personality disorder.
- Anger and Addiction Clinic completed a clinical trial that showed dramatic effects in working with clients with problem gambling and concurrent anger problems.
- Eating Disorders and Addictions Clinic has developed and evaluated effective ways of working with a client population that has experienced barriers to treatment for their concurrent problems.
- Integrative Group Psychotherapy Clinic is modeling treatments for trauma clients with addiction problems, as well as addiction support groups for people with concurrent severe mental illness.
- CD Consultation Liaison Service was initiated to support Emergency, General Psychiatry and Women's programs in assessing and treating clients with concurrent disorders; there are plans to expand the service to other programs and to the Queen Street site.
- Four beds (two beds in the Women's program and two in the General Psychiatry program) have been explicitly reserved for clients with severe concurrent disorders.

A number of clinical tools have been developed, and a CD continuing professional education (CPE) series is being developed for staff across CAMH. In the Toronto region, CAMH is collaborating with other mental health and addiction services, supported by a \$100k grant from the MOHLTC, to improve CD service capacities and to set up a CD network. CD is likely to remain a significant issue in clinical care over the next number of years.

Enhancement of Pharmacy and Medication Management Practices:

The need for enhancement of pharmacy and medication management practices is predicated on a number of key "drivers" including site redevelopment, computerized physician order entry and patient safety. In the current climate of patient safety, it will be necessary to enhance the role of the medication safety team within the context of overall organizational patient safety initiatives. In particular, compliance with new patient safety standards established by CCHSA will require the implementation of a comprehensive set of functions. In a similar vein, the CCHSA standards for pharmacy have recently been reviewed and revised and a final draft is in preparation. These standards, which will likely be in place prior to the next accreditation are more robust than the current standards and will require appropriate actions to ensure compliance. The patient safety imperative will require extensive use of bar-coding technology across all steps in the medication management process so that at the point of medication administration, there is confirmation that the correct drug is given to the right patient at the right time.

Clinical Trials Unit in the Addictions Program:

The Clinical Trials Unit is a secure, dedicated research unit that has the capacity to run all phases (I-IV) of pharmacotherapy trials. The unit is particularly suited to conduct early phase studies in that it has facilities suitable for serial blood sampling, medication dispensing and subject supervision and safety monitoring. The unit is equipped with pupillometers, vital sign monitors, a centrifuge and other specialized instrumentation. The Unit was developed to specifically run the NAOMI trial. However, the lack of heroin injection users in Toronto required a withdrawal from the clinical aspect of the study. CAMH will conduct an experimental study of heroin versus hydromorphone in 16 drug users to determine if hydromorphone can act as a reasonable substitute for heroin.

Women's beds in Law and Mental Health:

CAMH is committed to working with community partners to provide appropriate services and supports to forensic clients. CAMH, through its Law and Mental Health Program, provides minimum and medium security beds and the Forensic Outpatient Service. CAMH submitted a proposal (June 2005) to the MOHLTC outlining a series of initiatives intended to serve as longer-term solutions to the pressures within the forensic system, including funding for a 20 bed minimum secure unit at the College Street site and expansion of the Forensic Outpatient Service.

PURSUING RESEARCH INNOVATIONS AND PRIORITIES:

CAMH's research program has over 300 staff members (including scientists, lab technologists, research assistants and support staff), with an additional 100 trainees (graduate students and research fellows). CAMH collaborates with local, national and internationally recognized neuroscientists, clinical and social scientists, and offers first-rate facilities, a range of professional training and a province-wide network of community program staff. CAMH has a central role in the provincial and national commitment to research in this area.²¹

Research is organized into three departments: Clinical; Neuroscience; and Social, Prevention and Health Policy Research (SPHPR). The *Clinical Research* Department supports research, treatment and education goals through scientific publications, presentations and transfer of knowledge to evidence-based practice and to the community at large. The *Neuroscience Research* Department focuses on neurobiological mechanisms underlying mental illnesses, addiction and their respective treatments. The department benefits from state-of-the-art, in-house research facilities, including the Positron Emission Tomography (PET) Centre, which allows researchers to scan the brains of live human subjects, and the Transgenic Research Centre, which can alter the genetic makeup of laboratory mice to mimic human diseases such as schizophrenia, bipolar disorder or addiction. The *Social, Prevention and Health Policy Research* Department conducts innovative research using methodological and statistical techniques in areas that are relevant and topical. This research helps CAMH be among world leaders in conceptual knowledge.

CAMH's research program is currently going through a process to identify its vision and strategic priorities for research.²² In focus group discussions there has been a general consensus among the scientists about the factors that would ideally characterize the future research organization: academic scientific excellence, scientific and social relevance, and integration with clinical care, community and social policy. It was emphasized that CAMH should maintain a balance between "applied" research that addresses current issues, and "basic" research that lays the foundation of tomorrow's advances. Given CAMH's breadth of research from molecular neurosciences to social policy development, along with the increasing cost of science and the levelling off of resources, the strategic planning process has pointed out that CAMH will be increasingly challenged to maintain an internationally competitive level of excellence across such a broad mandate without choosing areas of focus. There was also a consistent view that research has a fundamental contribution to make to CAMH's ability to effectively deliver on its clinical, health promotion/prevention and educational goals. In the vision for the future these factors apply equally to CAMH as a whole resulting in an organization recognized as an international leader in research and also for its standard of clinical practice and influence on policy. The view was expressed that the organization is at a crossroad and the strategic choice is whether research becomes a valued partner in the interests of achieving its stated goals or remains a secondary consideration. The success of CAMH and its impact in terms of quality of care, education, health promotion and illness prevention can be enriched by research, but it will require commitment to address the challenges identified and leverage the opportunities presented.

²¹ See the Research Division's Annual Report.

²² "Vision and Strategic Directions for Research: A Report on the Internal Focus Group Discussions, CAMH". Innovation Institute of Ontario, July 7th, 2005 (draft).

It is expected that the strategic planning process for the research program will result in a focus on limited priorities that will allow for the growth of critical mass, followed by appropriate investments to achieve success (e.g., recruitment, support and resources). Another expected result of the process is adoption of a model that decreases barriers and increases incentives for the integration of neuroscience and social research (i.e., clinical research has historically been funded very differently from neuroscience and social research).

BROADENING OUR REACH IN HEALTH PROMOTION, PUBLIC POLICY AND SYSTEM REFORM:

Provincial Capacity Building:

CAMH has a provincial role to create, apply and disseminate knowledge regarding health promotion programs, evidence-based clinical applications and other resource materials for professionals. Programs and publications are produced collaboratively in interdepartmental, multi-disciplinary teams of CAMH staff. A strategic focus has been to build provincial capacity in the priority areas of youth, concurrent disorders and diversity. The goal is to develop, disseminate and evaluate research-based resources and tools that will increase the capacity and quality of prevention and treatment services related to addictions and mental health across the province.

(i) Youth Knowledge Exchange Program: *Educating Students About Substance Use and Mental Health*, a web based curriculum resource for teachers of Grades 1 to 12, received 400,000 web hits in 2004-05; *Talking About Mental Illness*, a resource aimed at raising awareness and reducing stigma for Grades 11 –12, is active in 44 school boards across the province; *Youth, Drugs and Mental Health*, a best practice resource for professionals for youth with concurrent disorders, which includes a clinical intervention called *First Contact*, has been disseminated broadly to youth serving agencies throughout the province.

(ii) Concurrent Disorders (CD) Knowledge Exchange Program: CAMH addiction and mental health system planning consultants across the province are disseminating *Concurrent Disorders Treatment: Models for Varied Populations* – an evidence based, best practice resource for service providers. The *Screening and Assessment Project* reviewed and are recommending screening tools for screening substance use problems in mental health agencies and screening for mental health problems in substance use programs; the project team is conducting four pilots of the CD Screening Roadmaps for Addiction and Mental Health providers. *Beyond the Label*, available on the CAMH web site, is an interactive training resource for front line service providers to address their own beliefs with respect to CD.

(iii) Diversity Knowledge Exchange Program: The *Best Practices in Community Education in Mental Health and Addiction with Ethnocultural Communities* is being culturally and linguistically adapted for seven ethnic communities, and a best practice manual for professionals will be produced. *Cross-Cultural and Diversity Training* has been provided to 536 service providers and allied professionals across the province, in an effort of promote diversity within and among agencies. *Asking the Right Questions* is a provincial training initiative for service providers who serve clients from the lesbian, gay, bisexual, transgender, two-spirit, and queer (LGBTBTIQ) community, on how to ask the right questions of people who access mental health and addiction treatment and services.

Evidence-based Policy Advice:

CAMH has demonstrated that it has an important role to play in influencing public policy. Our numerous submissions to the Kirby Commission, on behalf of CAMH and on behalf of the Ontario Hospital Association, relied on scientific evidence to make forceful recommendations. Our positions resonated in the Commission's Interim Report, and will hopefully be influential in the Final Report. CAMH took advantage of opportunities to advocate for healthy public policy during the hearings in preparation for the tabling of the Smoke-Free Ontario Act, the deliberations of the Beverage Alcohol Review Panel, and the Review of the Gaming Industry in Ontario. CAMH executives, scientists and staff have relied on sound, scientific research to influence the development of the National Framework for Action on Substance Use and Abuse in Canada; provincial leadership for the Health, Education and Enforcement Partnership (HEP) initiative; development of a child and youth mental health policy framework; and the Toronto Drug Strategy. CAMH worked effectively with key partners – CMHA / Ontario and the Ontario Federation – to ensure the mental health and addictions issues were fairly

and adequately addressed in regional consultations preparing for the establishment of the LHINs, and to advocate for the establishment of a provincial authority of addictions and mental health stakeholders. CAMH's commitment to diversity and marginalized populations also means a particular focus on critical mental health and addiction policy issues affecting these populations. Specific attention to areas like mental health and addiction implications of youth violence, forensics and race, and diversity accountability and planning inclusion in the health transformation agenda (particularly LHIN's) is important.

CAMH has a significant contribution to make to the shaping of public policy related to addictions and mental health, and determinants of health that impact on our clients. CAMH brings a strong evidence-based approach to public policy development and can make a significant contribution to ensure the successful implementation of these and other policy initiatives, including a role in the evaluation of policy implementation. We need to continue to be a leading and collaborative voice in influencing healthy public policy to address underlying factors that influence health, illness and social problems.

Public Education Initiatives:

McLaughlin Information Centre: Staff assisted calls increased 69% between 2003/04 and 2004/05, and calls to the Telephone Support Line increased 600% over the previous year. CATS and the McLaughlin Information Centre have collaborated on the development of a CAMH Clinical Program Database with the goal of improving ease of obtaining information about clinical programs and making referrals to CAMH clinical programs. *Film Festivals:* Film festivals in Toronto, Sault Ste. Marie, Thunder Bay, Peterborough, London and Ottawa continued to expand the scope of programming that raises awareness about substance use, mental health problems using film as the medium. The *Rendezvous with Madness* experienced a substantial increase in audience members, media attention and award winning films (*Ryan* by Chris Landreth received an Academy Award, and *Shake Hands with the Devil* received the Sundance Award). *The Workman Theatre Project (WTP):* The WTP was invited to participate in the 2005 Metamorphosis Festival that celebrated the vibrancy of the many types of artistic transformation that takes place in Toronto. The WTP seized on the opportunity to feature artists who use the *Jean Simpson Studio* – all artists who use this studio receive services from CAMH. The resultant *From Myth to Muse* profiled the collaboration of visual artists and baroque musicians. *Transforming Lives Awareness Campaign,* launched during Mental Health week (May 2-8, 2005), is a two-year campaign designed to educate the public about addiction and mental illness challenges, break down the stigma associated with these challenges, and improve access to information and services available at CAMH. Print ads in newspapers and magazines, and radio and television ads profile the personal stories of Ontarians' experiences with addiction and mental illness and direct people to CAMH's R. Samuel McLaughlin Addiction and Mental Health Information Centre.

International Health:

CAMH launched an Office of International Health (OIH) in April 2003, and has since established a wide-ranging global network of partners that includes universities in Brazil, Chile, China, the Caribbean and Sri Lanka; hospitals in Brazil, India, Mexico and Tanzania; Ministries of Health in Brazil, the Cayman Islands, Chile and Sri Lanka; and municipalities in Puente Alto (Chile) and Curitiba (Brazil). These partnerships are paving the way for new multilateral initiatives around global health challenges that cut across borders such as HIV/AIDS and substance abuse; drugs, alcohol and violence; and Indigenous mental health. The primary role of OIH programs is to work with international partners to assist in improving the quality of health care related to addiction and mental health issues. Built into each initiative has been a capacity building component to assist in empowering the country or region to cope with future issues – i.e., CAMH international initiatives have an enduring impact and engender a high degree of self-sufficiency in the process. CAMH exceeded its strategic goal of training 300 health professionals from around the world - since April 2003, 593 health professionals have participated in training and capacity building initiatives.

Recent catastrophic events (e.g., the tsunami in Asia, hurricanes in the Caribbean and the Gulf coast) and conflicts (e.g., Sudan) have pointed to the need for strategic initiatives to deal with trauma-related

mental health problems abroad. The ongoing HIV/AIDS pandemics - often associated with psychoactive drug-related problems - continue to require the assistance of external agencies. Provincially, SARS raised public awareness of our vulnerability to diseases that originated in far away places. As well, the catastrophic disasters abroad have had a palpable effect on the mental health of persons from those areas residing in Ontario (e.g., Canada is home to the largest Tamil community in the world outside of Sri Lanka, with over 80% of them living in Ontario). The growing capacity building needs in other countries and a high number of refugees and immigrants from the affected areas in Ontario reinforces the need for substantially greater attention to global health challenges. The Ontario Hospital Association (OHA) recognized such global interconnectedness and played a role in encouraging hospitals to be supportive of the victims of the tsunami. The OHA, in partnership with the Change Foundation, established the *OHAfrica Lesotho initiative for hope, health and healing*. Other hospitals in Ontario have established departments to address various global health challenges - University Health Network is supporting the Centre for Global e-health Innovation to conduct research to improve health for all; St. Michael's Hospital supports the Centre for Global Health Research which aims to generate and disseminate evidence for the control of major causes of premature mortality among the global poor; and Sunnybrook and Women's Health Science Centre supports an Office of International Surgery that works to improve the delivery of surgical services in many parts of the world.

Work with Partners on the Transformation Agenda:

CAMH has worked effectively with CMHA-Ontario and the Ontario Federation to ensure a sector response in the early stages of the Transformation Agenda (as described in section A). The partnership resulted in consistent messaging during the 14 local consultations, development of critical success factors for a transformed mental health and addictions sector, and advocacy for a provincial network or authority of mental health and addictions stakeholders. Clearly, the provincial government expects collaboration and values partnerships. CAMH must continue to play an active role – independently and with its partners – to:

- influence health system reform in Ontario, including planning and implementation of the LHINs, and influencing the form and content of a provincial or central role for health system planning;
- ensure that issues/concerns of the mental health and addictions sector are identified and considered during the planning and implementation of other transformation priorities; and
- expand its partnership with CMHA-Ontario and the Federation to include other sector partners – namely, consumers and families, other provincial organizations, community-based provider organizations, primary care physicians, other hospitals or institutions that provide mental health and addictions services, etc.

CAMH will have to make strategic decisions regarding its role in a LHIN environment. Key questions to be considered include: How will CAMH's provincial role be impacted in a multi-LHIN environment? How will the multi-LHIN environment in Toronto impact on access and continuity of care for clients? Will CAMH have to negotiate its role with each LHIN?

MANAGING CHANGE WITHIN THE ORGANIZATION:

There are over 2000 Ministry of Health and Long Term Care funded FTEs, around 140 FTEs funded by other sources (i.e., grants), and over 300 medical staff (including active, courtesy, fellow, honorary and consultant) who work at CAMH. The average age of staff is 44, compared to 42.5 years of age across the health care sector. Looking at groupings of staff, the average age for clinical staff is 43, management's average age is 47 (with the average age of executive leadership at 56 years), and corporate services staff have an average age of 46 years. Staff over the age of 55 make up 18% of CAMH's workforce. The average length of service is 8.5 years compared to 10.1 years for the sector.

A number of key initiatives – progress on the provincial government's Transformation Agenda, implementation of CAMH's Functional Program and site re-development, and increasing demands on the clinical programs in a constrained fiscal environment – will add extra pressure on CAMH staff and physicians. Corporate leadership efforts to address these pressures will become increasingly important.

Client Survey:

An organization-wide client satisfaction survey was conducted in the fall of 2004. Areas of high performance results included: staff returning calls within a reasonable timeframe; getting understandable answers to questions; staff helpfulness in helping clients deal with problems; adequate privacy; and clean and comfortable surroundings. The areas of highest dissatisfaction levels included: knowing how to submit feedback/complaints; feeling that treatment such as medications or counseling can be refused; staff informing clients about other services and supports that are available in the community; experiencing a reduction in symptoms; and the clients' feeling that they are doing better in work, school, or other usual activities. Results of the survey will be disseminated to the individual programs in the fall of 2005 and the program quality councils will likely undertake initiatives to address areas for improvement. The OHA will be adopting the same survey instrument that CAMH used in conducting client satisfaction surveys for the OHA Report Cards in the future - opportunities for comparisons and benchmarking will be available.

Staff and Physician Surveys:

CAMH staff and physicians completed satisfaction surveys conducted by the NRC+Picker Group in the fall of 2004. Results have recently been distributed to individual portfolios, with the expectation that accountability for addressing areas for improvement will fall to the Vice Presidents.

In June 2005, CAMH conducted a survey of employees in order to obtain a baseline measure of the safety culture in the organization. A literature review was commissioned to identify patient safety issues in the mental health and addictions field. The major patient safety issues in mental health settings were identified as medication errors, suicide prevention, violence against staff, abscondings, use of restraints, and close observation. The review noted there are inconsistencies in practices related to suicide risk assessment and close observation, which put both patients and staff at risk.²³ Further research will be undertaken at CAMH to identify potential triggers for concern, and to enhance patient safety. This initiative will support the new CCHSA requirements to improve patient safety in health care.

Commitment to Diversity: CAMH's Human Resources Diversity Plan has been approved and components of the Action Plans are being implemented. This initiative requires ongoing consultation with both unions in order to ensure a transparent process. The goal of the initiative is that the strategy becomes embedded into human resources policies and programming so that diversity becomes an inherent part of CAMH's work life. In the GTA, hospitals are looking to CAMH as the benchmark – we are considered the leader in the diversity area. An effort will be made to develop measurement tools to monitor our progress in bias-free hiring and mentoring initiatives.

New Performance Recognition System (PRS):

A PRS was implemented, as planned, in April 2005. The PRS system identifies an ongoing performance cycle outlining a timeline for completing job-specific performance and development objectives for management and non-union staff that link individual performance to CAMH strategic objectives. Individual performance objectives are expected to focus on setting, reviewing and measuring the achievement of business, resource utilization and human capital objectives. Individual development plans are expected to develop core competencies related to the achievement of business objectives. Accountabilities help fully define each position beyond specific objectives or targets in a given fiscal year. The next phase is to build on PRS job-specific objectives to create a longer term and more comprehensive set of accountabilities for each position.

Back Office Transformation:

CAMH has been working with Hospital Business Service (HBS) and 13 other hospitals in planning for the implementation of this initiative (i.e. transforming finance, payroll, purchasing, materials management and some human resources functions). CAMH has been actively involved in working

²³ Patient Safety in Mental Health, Literature Review and Recommendations – Final Report. Sue Boockey-Bassett, June 2005. Submitted to the Patient Safety Steering Committee, CAMH.

with the government, HBS and various unions in an attempt to either reach a labour relations strategy that would allow transition of the individuals required through integration of the various unions, or have government enact appropriate legislation. CAMH has also been encouraging a re-examination of the business case as scope, timeframes and funding circumstances have changed. HBS has recently approved a staged approach to the transformation of the back office functions starting with the strategic contract management function in Supply Chain, allowing for a demonstration of benefits while allowing time to obtain a negotiated labour framework. HBS has faced serious financial challenges and has recently called upon members to flow 25% of their costs for the 2005-06 fiscal year, which CAMH has done.

E Health Initiatives: E-health was identified as a key strategic thrust in the 2002 Information Management strategy for CAMH. E-health initiatives enable CAMH to address its education, outreach, and information dissemination mandates. The electronic clinical record, another strategic thrust, is viewed as a mechanism to provide high quality clinical care by having the ability to create, transfer and store client related documentation in a fast and efficient manner. The electronic IPCC prototype was available by July 2005 and it will be piloted in the fall 2005. In consideration of the redevelopment planning, the EHR strategy is being revisited - a detailed plan will be developed. A new Information Management strategy is currently being developed with a draft expected by Fall 2005.

Accountability Framework with MOHLTC:

For the 2005/06 fiscal year, the MOHLTC announced multi-year funding tied to the Hospital Annual Planning Submissions (HAPS) – the vehicle through which hospitals will identify service consolidations and reductions, if necessary, in order to achieve a balanced operating budget - and the Hospital Accountability Agreements (HAA) - the tool required by the MOHLTC to meet the accountability requirements of the *Commitment to the Future of Medicare Act*. Cumulative funding announced for CAMH over the next 3 years totals 7.8% (2.8% in 05/06, 2.6% in 06/07 and 2.0% in 07/08). Based on category-specific cost assumptions CAMH anticipates inflationary assumptions to be at least 12.5% over the same 3-year period. The shortfall of 4.7% between assumed cost pressures and announced funding translates to a \$9.5M real decrease in base funding by 2007/08.

For 2005/06, in order to balance its budget, CAMH had to find \$3.2M in savings. These savings came from across the organization with a greater burden placed on Corporate and Policy, Education and Health Promotion (PEHP). In 2006/07, to balance its budget as required by law, CAMH had to come up with \$2.9M in savings that were spread evenly across the organization.

Implications of the accountability framework for the renewal of CAMH's strategic plan include the following:

- Goals and initiatives included in the strategic plan must be achievable within a constrained environment and with a requirement of balanced budgets;
- The constrained fiscal environment and the policy focus on integration will drive interdependency among hospitals and community-based provider organizations to meet community health needs with available resources;
- We will need to increasingly focus on those services and programs that we are uniquely positioned to provide;
- We will need to continue to be responsive in the future to possible new hospital funding allocation methodology; and
- We will need internal tracking mechanisms to support the accountability requirements of the negotiated legal documents (as was included in the 2003-06 strategic plan)

SUMMARY:

- CAMH has experienced significant achievements in all of its key mandates.
- CAMH will face the ongoing challenge of recruiting and retaining high quality clinicians and researchers, in an environment that is increasingly complex.

- CAMH has a strong track record in research, but it will be important for the organization to clearly articulate and support its evolving research role.
- CAMH is increasingly seen as a system player with an increased role and influence within the sector – CAMH has demonstrated its commitment to integrated and coordinated services through a number of initiatives such as CATS, the ER Alliance, withdrawal management services planning, and Alternative Milieu beds.
- There are significant opportunities for CAMH to influence public policy – a key mandate for the organization (in addition to care, research, education and health promotion). There is significant support – internally and externally - for CAMH involvement in this area.
- Relationships with client and family organizations are maturing - collaboration on the Bill of Client Rights and the Family Initiative has been a model for working together.
- There is a need for CAMH to transition its provincial role in order to be effective in a LHIN environment.
- Redevelopment will be an overriding focus for CAMH over the next strategic planning period.

CONCLUSIONS:

The following conclusions can be made:

- Health care will remain a high priority issue for Canadians.
- The federal and provincial governments will continue to focus on health system reform and accountability.
- Health promotion and disease prevention, and the need for intersectoral collaboration are gaining prominence at the federal, provincial and municipal levels, as the impact of the burden of illness and disease on the sustainability of the health care system, and the quality of individual and community health is becoming better understood.
- Consumers, their families and the general public will have high expectations of us – we must continually improve standards of care.
- We are operating in a constrained environment - constraint is expected to continue through the duration of the next strategic planning cycle.
- The development of indicators, and measurement of impact will increasingly be expected.
- Ontario, and Toronto in particular, is becoming an increasingly diverse community.
- The mental health and addictions sector must be unified and strong to ensure that mental health and addiction issues are not lost in a regionalized system.
- The provincial government will increasingly emphasize the importance of a continuum of mental health and addiction services from hospital to community. The provincial government has demonstrated that it will invest in those organizations that have a proven capacity to “get the job done”.
- The province will increasingly hold hospitals accountable to each other and to community-based service providers, and to require consultation and transparency in decision-making.
- Hospitals and community-based service providers will have to develop and agree upon clear roles and responsibilities for the various parts of the system.
- CAMH’s role as the major mental health and addictions teaching hospital will need to continue to be developed and refined.

It will be critical for CAMH to have a clear understanding of the following during the renewal of its strategic plan:

- **Our clients** - who will receive services, and how clients and families are engaged in decisions about care, prevention and health promotion.
- **Our role and value-added uniqueness** - in continuing care/chronic care, case management, early intervention; the role of our satellites; our role in building capacity across the province and internationally; our role as a specialty/teaching hospital; our role in creating new knowledge through research; our role in implementing the latest in scientific advances into clinical practice, professional development, system change and policy.

- **Our partners** - how we work effectively with our partners in developing and working in a new system; how we work with university and community partners to support knowledge creation, knowledge transfer and capacity building; how we work with partners to advocate for the inclusion of consumer/survivor initiatives.
- **Our staff** - how we maintain a healthy workplace through difficult transitions, and ensure staff are equipped to work in a changing environment (e.g. implementation of the Functional Program and the Transformation Agenda).